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Wednesday 5 April 2017

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Mercredi 5 avril 2017

Standing Committee on Public Accounts

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Auditor General:

Ministry of Health
and Long-Term Care

Comité permanent des comptes publics

Rapport annuel 2016,
vérificatrice générale :

Ministère de la Santé
et des Soins de longue durée

Chair: Ernie Hardeman
Clerk: Katch Koch

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Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
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CONTENTS

Wednesday 5 April 2017

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON PUBLIC ACCOUNTS

COMITÉ PERMANENT DES COMPTES PUBLICS

Wednesday 5 April 2017

Mercredi 5 avril 2017

The committee met at 1230 in room 151, following a closed session.

2016 ANNUAL REPORT, AUDITOR GENERAL

MINISTRY OF HEALTH AND LONG-TERM CARE

Consideration of section 3.08, large community hospital operations.

The Chair (Mr. Ernie Hardeman): I call the April 5 meeting of the public accounts committee to order. We're here this afternoon to deal with the large community hospital operations, section 3.08 of the 2016 annual report of the Office of the Auditor General.

We have with us this afternoon a delegation. We have the Ministry of Health and Long-Term Care. I was just sitting here, thinking maybe we should have a special chair, because it seems that for at least every other review we're doing, the Deputy Minister of Health and Long-Term Care gets the privilege of presenting to the committee.

Dr. Bob Bell: Chair, thank you.

The Chair (Mr. Ernie Hardeman): We also have Rouge Valley Health System, Trillium Health Partners and Windsor Regional Hospital. I want to welcome you all here to the committee this afternoon.

As we review this, we will provide 20 minutes of opportunity for the deputants to collectively make their presentation, and then we will have the questions and comments from the committee. They will be in rotation, 20-minute rotation—this one starting, I believe, with the government side. The government will go first, then the official opposition and then the third party, in 20-minute rotation. The second time, we will divide the time that's left equally for the three parties to take us to 2:45.

With that, again, we thank you for coming in.

I just want to tell the delegation that, in between, I do have to leave for a while, so we will leave the meeting in the capable hands of the Vice-Chair. I apologize for that. I'm not walking out on your presentation.

With that, we'll turn the presentation over to you, Deputy.

Dr. Bob Bell: Thank you, Chair. My name is Bob Bell, Deputy Minister of Health. Thank you for the opportunity to address the Standing Committee on Public Accounts with respect to the Auditor General's report on large community hospital operations.

With me is Melissa Farrell, assistant deputy minister, who oversees the health system quality and funding division. At the far end of the table is Michelle DiEmanuele, president and chief executive officer of Trillium Health Partners. Beside Michelle is Mr. David Musyj, president and chief executive officer of Windsor Regional Hospital. To my right is Madame Andrée Robichaud, former president and chief executive officer of Rouge Valley Health System, and interim president and chief executive officer of the Scarborough and Rouge Hospital.

We thank the Auditor General of Ontario, Bonnie Lysyk, and her staff for her report on large community hospital operations. We very much appreciate her advice on strengthening large community hospitals in Ontario. The Auditor General has done a considerable amount of work to investigate the efficiency and the effectiveness of our large community hospitals. The Ministry of Health and Long-Term Care appreciates the comprehensive audit conducted by the Auditor General, and we welcome the recommendations contained in the report.

I would now like to discuss how this important work has supported our plan to improve hospital and health systems in Ontario.

In Ontario, as you know, there are 143 public hospital corporations, accountable to the 14 local health integration networks, including large community hospitals, along with small community hospitals, teaching hospitals, chronic care and rehabilitation hospitals, and specialty psychiatric hospitals.

Although accountable to LHINs, local health integration networks, hospitals are independent corporate entities run by their own management teams and boards of directors. They make operational decisions on how to allocate funds within the terms and conditions of the funding they receive, and are accountable for the sustainability of their operations and the quality and efficacy of the care they provide.

In addition, Ontario hospitals are subject to external accreditation, board oversight, and provincial policies to monitor performance, quality and patient safety.

Hospital funding in Ontario overall has risen from $11.3 billion in 2003-04 to about $17.5 billion in 2016-17, representing a 55% increase. In the past year, 2016, Ontario invested more than $485 million, or about 2.8% incremental, to all hospitals to provide better patient access, and responding to growth in demand and to

reduce wait times for services. This funding supported priority services such as organ and tissue transplantation, additional volume-counted procedures such as cataract surgery and hip and knee replacement for arthritis, as well as funding for our small and specialty pediatric and psychiatric hospitals.

As part of the Excellent Care for All Act, the ministry has reformed the way hospitals are funded, to provide equitable support for efficient, high-quality care and to help ensure that hospital funding generally follows the patient receiving care. By introducing bundled care that increasingly covers all steps of the patient's journey during a hospital encounter, funding reform is improving the coordination of health care and making the patient's experience more seamless.

Introduced in 2012, Health System Funding Reform has improved the efficiency of Ontario's health care system. The average length of stay has reduced, cost effectiveness has improved, and analysis of nurse-sensitive outcomes like patient falls, pressure sores and urinary tract infections show improvement across the system.

Health System Funding Reform has two components. The first component is the health-based allocation model, or HBAM. HBAM is an evidence-based health funding formula that enables the government to allocate funding based on factors such as local population growth and demographics, complexity of patients being treated within a facility, as well as socio-economic status of the patients served, hospital type and rurality. All hospitals now carefully analyze and adjust their models of care in order to optimize their HBAM results.

The second component of Health System Funding Reform is quality-based procedures. The quality-based procedures program is designed to reduce variation in patient care and ensure that all patients receive standardized, best-practice care developed from advice provided by expert panels. QBPs are developed in collaboration with agency partners such as Health Quality Ontario, Cancer Care Ontario and the Cardiac Care Network.

To date, Ontario has implemented QBPs for 24 types of procedures and diagnoses at admission of the more common types of procedures and diagnoses, including hip and knee replacement surgeries, cataract surgeries, cancer treatment and heart and lung failure. This translates into almost 300,000 procedures and admissions since 2011.

There have been a number of benefits from the introduction of quality-based procedures. For instance, more stroke patients are being treated in specialized stroke units, with reduced hospital lengths of stay, lower readmission rates and more common admission to specialized stroke rehabilitation facilities. Chronic obstructive pulmonary disease patients have increased primary-care follow-up rates in a timely fashion, reduced hospital lengths of stay and improved clinical practice, with more use of non-invasive ventilation. And a higher proportion of hip fracture patients are receiving surgery within 48 hours.

Currently in Ontario, 85 hospitals, including large community hospitals, are participating in Health System Funding Reform. Since the introduction of HSFR, hospitals have made improvements in achieving a greater degree of efficiency, while standardizing common diagnostic admission criteria, quality and outcomes.

We're obviously committed to improving quality and patient safety across Ontario hospitals, and have established and implemented several requirements to strengthen patient safety in hospitals, including the mandatory public reporting of patient safety indicators in hospitals and the strengthening of existing patient safety legislation and regulation.

Today, Ontario hospitals are required to report publicly on nine patient safety indicators, including hand hygiene compliance, hospital-acquired infection rates, surgical site infection prevention compliance, and surgical safety checklist compliance.

We also use hospital service accountability agreements and quality improvement plans to enhance oversight of funding and outcomes, respectively.

1240

Under the Excellent Care for All Act, all public hospitals are required to develop, implement and publicly post annual quality improvement plans. These plans contain targets and performance measures that a hospital management team aims to achieve, and a description of how they plan to achieve these goals.

Hospital administrators are responsible for establishing systems for analyzing critical incidents and developing system-wide plans to avoid or reduce the risk of further similar incidents. Additionally, critical incident data is reported to the hospital's quality committee at least twice a year, and must be considered when developing the hospital's annual quality improvement plan.

Another important step toward increasing transparency and improving quality in Ontario's health care system is the Quality of Care Information Protection Act, or QCIPA. QCIPA was enacted to encourage health care professionals to freely share information about serious unintended events and quality improvement matters in their organizations. QCIPA has been strengthened in 2016 and will come into force later this year, with partnership and change management efforts provided by Health Quality Ontario and the Ontario Hospital Association.

It reaffirms the right of patients to understand what happened when something went wrong, as well as free hospital staff to share information about their opinions as to what could contribute to improve patient safety and prevention of critical incidents occurring in their facility. It will also enable hospitals, with the leadership of the Ontario Hospital Association and Health Quality Ontario, to share information about mishaps that occur in hospitals and, again, share methods of improving systems so that critical incidents are less likely to occur in Ontario's hospitals.

We're also committed to addressing wait times for specialists and specialist services. Since 2003, Ontario has invested over $2 billion for more than three million additional procedures to help reduce wait times. We

continue to collaborate with the local health integration networks to determine ways to address wait times and risks to patients.

We continue to lead by example. With the support of clinical expert panels, we've developed access targets for how long a patient should wait to see a speciality clinician. We're the first province to finalize wait-time targets for speciality consultation—so-called Wait 1 targets—as well as the currently published Wait 2 targets, which represent the time from a patient seeing a specialist to the time they have an intervention like a surgery.

Since 2005, our focused efforts to improve wait times have resulted in over 322 million days saved waiting in wait-time service areas. Over 80% of surgical patients are treated within publicly reported wait-time targets. Just this March, the Canadian Institute for Health Information released its annual Wait Times for Priority Procedures in Canada report, noting that Ontario has the highest percentage of patients achieving wait-time targets, with 81% of patients receiving knee replacements within target, and 85% receiving hip replacements within target waiting times. CIHI's report also noted that Ontario has the lowest 90th percentile wait times for diagnostic procedures, with MRIs at 99 days and CAT scans at 41 days.

The focus on enhancing wait times and standardized protocols of care across our hospitals has resulted in objective outcomes that are recognized as best in the world in several areas. For example, international comparisons across OECD countries for the four most common cancers show that Ontarians have leading outcomes in five-year cancer survival. The world's leading protocol for managing acute heart attacks, or STEMI protocol, was initially described at the Ottawa heart institute and is now accessible to more than 90% of Ontarians.

We've dealt with the challenge in acute neurosurgery care that the auditor referenced in her report, when, in 2010, more than 200 Ontarians were sent out of country for acute neurosurgical treatment because of insufficient neurosurgery human and facility capacity. Today, with substantial expansion of the neurosurgery workforce and investment in neurosurgery resources and information management related to referrals, all patients with neurosurgery emergencies receive treatment at one of our 13 coordinated neurosurgery centres, including Trillium Health Partners and Windsor Regional Hospital.

We have also supported improvements in our emergency department wait times during a time of significant growth in demand for ER services. Since April 2008, an additional 125,000 patients annually are visiting emergency departments, representing a 21% increase in emergency utilization. Despite this growth, the overall emergency department length of stay decreased by 4.8% across this time period, from 9.4 hours to nine hours, with 92% of low-acuity patients receiving care and departing within the four-hour standard.

We'll continue to build on this work and wait times, turning our focus next to enhancing our public reporting, as has been recommended in her report by the Auditor General. We are currently working with Health Quality Ontario on the next generation of wait time reports, partnering with patient advisory groups as well as HQO, to ensure that our wait time reporting is more meaningful to the public as well as being more accessible, on one website, and understandable for a wide variety of services.

The primary challenge facing Ontario hospitals today—and I think my CEO colleagues will agree—is the presence of alternate level of care, or ALC, patients who are ready to leave hospital from a medical perspective but are unable to immediately return home. These patients may be waiting for placement in long-term care, rehabilitation hospitals, home care or a variety of other services in the community. At present, 16% overall of patients in Ontario hospitals are classified as ALC. Hospital leaders recognize that ALC problems contribute to ER overcrowding and a risk of cancellation of scheduled surgery, although, fortunately, surgical cancellation remains a rare event. ALC is a problem that needs a solution not in the hospital but, rather, in the community.

In December 2016, the government passed the Patients First Act to address the changes needed in primary care, home community care, and community mental health, to address ALC challenges. The act makes careful structural changes to our health care system to set the stage for an opportunity for transformation over the upcoming years. Structural changes will drive integration in our health care system, empower local health care planning, strengthen primary care and integration of home and community care and primary care, as well as integration of mental health services, and enhance our focus, crucially, on population and public health planning. It will contribute to better and more standardized home care, more effective integration of primary care with hospitals, as well as strengthening mental health services in the community. All these improvements will address issues that result in higher rates of ALC.

Our work now is setting the stage for a health care system that is designed to meet the challenges of an aging population, with increasingly complex health care needs, that the changing demography of Ontario represents. It is driven by what we heard from patients and families, from experts and from the Auditor General in a variety of reports about where the health care system needs to enhance its procedures and its care, to better meet Ontario needs, now and in the future.

We are in the process of implementing this legislation, with our primary current focus on integrating the staff and function of community care access centres into LHINs over the upcoming months.

Meanwhile, we continue to make progress on the Patients First road map to strengthen home and community care. This road map is driving improvements in 10 work streams, to provide accessible, consistent, standardized and high-quality home care. We look forward to continued collaboration with our health sector partners, including primary care, mental health and addictions providers, to realize the transformative potential of Patients First.

In conclusion, the ministry is looking forward to continuing this important work and remains committed to addressing the recommendations made by the Auditor General.

Thank you, Chair.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

I did neglect to mention to the other panel members, as we get into this part of the program, to make sure, the first time you answer a question, that you identify yourself for Hansard, to make sure we don't get confused with who said what in the Hansard.

With that, the first round of questions goes to the government. Mr. Dong.

1250

Mr. Han Dong: Thank you, Deputy. It's good to see you again.

Dr. Bob Bell: It's good to see you, sir.

Mr. Han Dong: I recognize that Michelle is there. We used to be colleagues working in the same office.

The government obviously recognized the growth in our aging population. We are aware that this will put extra pressure on certain areas of our health care system. That's why the government continues to invest in programs and resources that will help seniors and provide the support they need.

One of the innovative programs our government supports is the assess and restore guideline, which helps seniors who require short-term rehab and restorative care treatment. Can you tell the committee more about this program and how it helps to improve health outcomes in our health care system?

Dr. Bob Bell: Thanks for that question, and I'm going to—

The Chair (Mr. Ernie Hardeman): If I could, just before you answer the question—again, I want to remind the committee that this hearing is about the large community hospital operations.

Mr. Han Dong: Okay.

The Chair (Mr. Ernie Hardeman): So if the question does not refer in any way to that section, it's very difficult for the deputy to have an answer that does fit.

I would caution the member to make sure we stay on this section.

Mr. Han Dong: Thank you, Chair, for the reminder.

Deputy, could you tell us, within the scope of this report, your answer to the question I just asked?

Dr. Bob Bell: Yes. Chair, this does indeed reflect one of the problems raised by the Auditor General, which relates to patients remaining in hospital who could possibly be treated better in the community.

To provide the details, I'm going to introduce Melanie Kohn, who is director of the hospitals branch.

Dr. Melanie Kohn: Thank you for your question. My name is Melanie Kohn, and I'm the director of the hospitals branch at the Ministry of Health and Long-Term Care.

Today, it is my privilege to talk to you about the assess and restore guideline, an important program that we have invested in, designed to help seniors who require short-term rehabilitation and restorative care treatments, which is having a profound impact on the health care system, individual organizations, communities, patients and their families.

I'd like to begin by telling you a patient story. It's the story of Stan, an assess and restore patient. Stan is 81 years old and is the primary caregiver to his wife, Linda, who suffers from dementia.

Recently, Stan was diagnosed with congestive heart failure and was admitted to a local large community hospital for treatment and therapy. As the primary caregiver to his wife, Stan was hesitant to leave her and his home.

As part of the assess and restore program, Stan received rehabilitative care twice a day, every day, in hospital to build up his mobility and strength. Soon after, he was able to go home with a comprehensive discharge plan that was specifically tailored to his unique individual patient needs.

He received additional rehabilitative services from a physiotherapist at his home, and an occupational therapist completed a home safety assessment. This enabled Stan to be at home in a safe environment, where he could continue to heal while supporting and caring for his beloved wife. This would not have been possible without the ministry-led implementation of the assess and restore program.

In 2013, the ministry implemented its assess and restore guideline across the 14 local health integration networks, hospitals, community care access centres and other care organizations. This program is intended to support frail seniors who have experienced a recent but reversible functional loss, to recover their functional ability so that they can continue living in their homes and in the community.

The types of patients who are typically included in this assess and restore program are elderly and have complex care needs, often with three to 10 comorbidities, such as congestive heart failure, diabetes, respiratory illnesses, mobility challenges and the like.

One of the great benefits of this program is that it has been structured with the LHINs, hospitals, CCACs and other providers to be able to develop programs that meet the patients' needs, and it allows them to arrive at solutions that are meaningful and effective to them.

I've had the privilege of speaking with front-line hospital caregivers about the assess and restore guideline, to hear about their perspectives on the difference it's making. According to one clinical team manager, the assess and restore program is holistic in its approach. It allows the interconnected relationship of what they call the mind, body and spirit, allowing patients to return home safely—

Mr. Randy Hillier: Point of order, Chair.

The Chair (Mr. Ernie Hardeman): You have a point of order?

Mr. Randy Hillier: Yes. I know what this committee's purpose is. I know that stories are interesting. But is

there any relevance of this assess and restore program to the Auditor General's documents and reports that we have in front of us today?

The Chair (Mr. Ernie Hardeman): I think that's a good question. I would just remind us of my comments when we started: We must relate not only the question, but the answer to that section of the auditor's report that deals with the large community hospital operations.

In fact, if the answer is directed at the quality of overall—and that's not to this section of the report. With that, we just ask the deputant to carry on.

Mr. Han Dong: Point of order, Chair. I have something to say. Thank you.

First of all, I completely agree with that—

The Chair (Mr. Ernie Hardeman): If it's to that point of order, I've already ruled, so there's no further discussion on a point of order after the Chair has ruled.

I'm sure that the deputant will get back to the issue at hand.

Dr. Melanie Kohn: This is directly related to recommendation number 9, as an example of the kinds of investments that we're making with hospitals to actually help senior, frail elderlies in particular to be able to rehabilitate and actually restore their function and help them. I've got some great data that I would like to share with you, in fact.

Since its launch in 2013, the ministry has invested over $40 million, which supported over 40 pilot projects and initiatives across the province. We've provided services to over 28,000 seniors and trained over 2,000 clinicians. This investment has encouraged large local innovation and has helped health care and community organizations develop and respond, and create programs to meet their local needs.

I'd like to tell you a few of the results that we've seen in several of our areas. In primary care, for example, the South West and Waterloo Wellington LHINs have formalized online care pathways, which have resulted in increased utilization of community resources to support aging in place.

In the North East LHIN, 100% of high-risk older adults identified in primary care, who were admitted to bedded rehab, were discharged home, following rehab.

In acute care, in particular, initiatives are focused on proactive screening and increased access to rehabilitative services, improved patient flow from acute to subacute and rehabilitative beds, and enhancement to community rehabilitative and supportive post-care transition programs.

One example in the Central LHIN: The community care access centre and hospitals and health links have partnered to ensure the delivery of seamless, integrated care for complex elderly patients transitioning from hospital back to the community.

At a local large community hospital, patients are identified through a standardized screening tool for the emergency department as eligible candidates for assess and restore programs and, in fact, can be discharged directly from the emergency department on the assess and restore program. Once identified, patients undergo a multidisciplinary assessment and treatment in hospital, which is seamlessly connected with the CCAC in their community.

The assess and restore funding has also allowed some hospitals to enhance their staffing complement over the weekends and has enabled patients to receive rehabilitative and support services twice a day, every day, seven days a week, and, in fact, has enabled discharge on the weekends as well.

These initiatives and others have demonstrated results:

—in the Central East LHIN, a 4.89-day reduction in length of stay;

—in the Champlain LHIN, decreased wait times for geriatric rehab to less than 24 hours for 87% of patients;

—in the Central LHIN, only 1% of patients experience unplanned emergency department visits in 30 days following discharge; and

—in-home and ambulatory care initiatives were targeted to implement cross-sectoral clinical care pathways to community services and to enhance in-home and ambulatory rehabilitative services post-discharge from acute, subacute and bedded rehabilitative services focused on improving functional independence.

This has resulted in reduced wait times for post-discharge services in the Central East LHIN and improved patient satisfaction and feelings of confidence of patients that their health would improve. Through the enhancement of in-home restorative services, the Waterloo Wellington LHIN was able to discharge patients home an average of 6.7 days earlier.

1300

Collectively, hospitals and LHINs have reported increased utilization of community resources to support aging in place, improved access and patient flow from acute to subacute in rehabilitative care, reduced length of stay, improve patient satisfaction, standardized proactive risk screening, and earlier discharge supported by the enhancement of in-home restorative services. As part of Patients First: Action Plan for Health Care, the ministry remains committed to improving access to services and patient-centred care to improve quality of life.

Dr. Bob Bell: Thanks, Melanie. With respect, I think this demonstrates the fact that effective use of Ontario's large community hospitals extends beyond the four walls of the hospital to the organization of services in the community. I don't know if my colleagues would like to reflect on that sense of community organization being crucial to ensuring that a hospital is used for the right purposes.

Ms. Michelle DiEmanuele: Maybe I'll just comment. I'm Michelle DiEmanuele from Trillium Health Partners.

First, it would be remiss of me not to thank the auditor and her team. The auditor actually spent some time in our hospital—several hours, in fact—working through the various parts of the hospital, which would include the discharge component and Rudy and his team. I particularly really want to thank you publicly for the work that you did, but also in helping us deliver our services and

not getting in the way of patient care while we were doing this important audit. So thank you to your team.

Mr. Rudolph Chiu: Thank you for your co-operation.

Ms. Michelle DiEmanuele: I think this issue of ALC and alternative care, which really gets at the heart of some of the recommendations around the utilization of resources, is key. What we're seeing now is a patient population that comes through our doors more than once. In fact, many of them have several issues that we're dealing with. So the complexity of the set of services that is required, both when you're in hospital and outside of the hospital, does require that sense of community partnership.

To some extent—and there are many recommendations that the auditor brings forward that we have certainly learned from and are enacting, but I think fundamentally you have to look at the complete system and the utilization of resources when looking at a hospital, in terms of what's within our control and what isn't within our control. Certainly, some of the examples given by the director of the branch would indicate that there has been a lot of investment to help us in that regard.

One of the areas you didn't talk about quite specifically was bundled care. Bundled care is an initiative on the part of this government and this ministry which has helped us reduce the lengths of stay in our cardiac program, in particular, by several days. If you equate that to resources, it's several beds. If you think about being able to drive that particular delivery mechanism across our surgical platform, as an example—and our surgical platform is equal to Ottawa, which is an academic health centre; the two of our hospitals have the largest surgical platform in this province—that presents an enormous opportunity.

I think the piloting work that we've done is another example of that—Deputy, as you indicated—that is part of that partnership that we have with both the community and the hospital sector.

I would also want to thank our partners in community and social services, who help in that regard as well.

Mr. Han Dong: Thank you very much for the answer, and thank you for clarifying the fact that the question and the answer are relevant to the report.

With that, I want to ask a second question. How much time do I have, Chair?

The Chair (Mr. Ernie Hardeman): You have about five minutes left.

Mr. Han Dong: Okay. The Canadian Institute for Health Information recently released a report that detailed Ontario's progress in reducing wait times. The report illustrated that Ontario is beating benchmarks for wait times on knee and hip surgery, radiation therapy, was well as access to MRI and CT scans. I know the government is committed to reducing wait times even further, and that our government is committed to making the necessary investment, as well as initiating new programs to do this.

Deputy, could you please tell the committee—speak to some of the progress that we've made, as well as the recommendations made by the Auditor General related to wait times for key services, and the way the information is publicly shared?

Also, can you specifically speak to programs in place to support access to specialists? I know this a priority to my constituents in Trinity–Spadina. Just in case, I want to help clarify that this has to do with the recommendation of the Auditor General in—I think it was recommendation 7, so we know it's relevant. Please go ahead and give the answer.

Dr. Bob Bell: Thank you for that question.

I'd like to introduce a director of the health quality branch, Fredrika Scarth.

Ms. Fredrika Scarth: Thank you for your question. I'm happy to be able to address it here.

The deputy minister spoke a little earlier in his remarks about the successes we've had on wait times. I can expand on some of our future directions; in particular, in response to the findings of the Auditor General now.

As you may know, in 2003-04, the Wait Time Strategy was launched in the province to improve access to five key health care services: cancer surgery; cardiac procedures; cataract surgery; total hip and knee replacements; and diagnostic imaging, both MRI and CT scans. In 2005, we began to publicly report on the health system's performance on these procedures. Between 2005 and 2010, the strategy was expanded. And today we collect and report wait times for over 200 surgical procedures and diagnostic imaging procedures in the province.

Overall, we have invested over $2 billion in that time frame for more than three million additional procedures to help reduce wait times, and our focused efforts, as you heard from the deputy minister earlier, have resulted in over 322 million days saved for patients waiting in those service areas for services in Ontario.

We're very proud of the results that we have seen to date. Overall, over 87% of patients in our province receive their services within the publicly reported wait time targets. We've been recognized as a leading jurisdiction for wait time reporting and for wait time performance. In fact, according to the Canadian Institute for Health Information's annual Wait Times for Priority Procedures in Canada report, which was just released in 2017, Ontario is leading the way among all provinces and territories in the country on wait times, with the highest percentage of patients receiving knee surgery within their target time frame at 81%; the second-highest performer among all of the provinces on hip replacement, with 85% of patients receiving their service within the target time frame; and we are the top performer in the country for diagnostic imaging.

We continue to lead by example. As the deputy remarked, we are supported by clinical panels who advise us on target time frames, who advise us on the procedures we should be reporting on and how we should report on them. In addition, we are reaching out to patients to seek their input on how we report against all of these procedures.

I will speak a little bit more about how we're moving forward on reporting to build on the response that you heard from our deputy minister.

We're also, though, I should say, supporting the development of innovative and evidence-based models of care to ensure that patients get access to specialists and specialized care when they need it. These models, which we have demonstrated and piloted in our province, have shown tremendous results for patients, providers and the system. We're working to ensure that these programs will be available for more Ontarians.

I'll expand on these areas now. In terms of reporting, the auditor highlighted for us some areas of improvement in our public reporting on wait times that we agree with and we're actively moving to enhance. The auditor flagged for us that it may be confusing for the public to see our performance on wait times reported globally on all priority categories together—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time that you have. We will now go to the official opposition.

Ms. Lisa MacLeod: I'll be very brief because I'm actually going to have to replace the Chair in the chair.

I wanted to follow up with this issue of ALCs. It's something that I've been working on since I was elected in 2006. It doesn't seem to be improving. I typically work with Tom Schonberg at the Queensway Carleton Hospital. We have seen a great deal of bed blocking. We've seen in this auditor's report that in March 2016, 4,110 ALC patients were occupying hospital beds even though they were no longer needed. Half of those, over 2,000 in the province of Ontario, were waiting to get into long-term care.

The issue that I want to raise is—I understand the Aging at Home Strategy. It has failed some of my constituents miserably. I've had an Alzheimer's patient having to be cared for by her cancer-stricken husband, both of whom have passed on now, with no long-term-care beds. Yesterday I spoke to somebody who waited 18 months to get into the Osgoode Care Centre.

By the way, the Osgoode Care Centre is the only rural long-term-care facility inside the city of Ottawa. They are now having to do millions of dollars in upgrades and they are not getting any money from the province.

1310

So when I look at this number of 4,100 ALC patients occupying hospital beds when they were no longer needed and half of them were waiting to get into an LTC and then we're putting an additional burden on some of these smaller long-term-care facilities, how in the world are we to expect that this is going to be dealt with in any meaningful way? What are you doing to ensure that funding to hospitals accurately reflects patient needs, so that surgeries are delivered when needed and the beds aren't being blocked?

This is not new; it has been a long-standing issue. As I said, I've been elected 11 years as of last week, and I've been working on this. What are the programs and initiatives that you're using in the ministry in the past few years, and why have they been so ineffective?

Finally, can you help me with the long-term-care facility in Osgoode ward in the city of Ottawa, because they need your help?

I will now go to the Chair and he can talk to Randy.

Mr. Randy Hillier: Actually, talk to Jeff.

Ms. Lisa MacLeod: Yes.

Dr. Bob Bell: Shall we tackle that question? We'll tackle that question.

As you know, 10,000 long-term-care beds have been added to the system over the past 12 to 13 years, and another 30,000 beds are scheduled to be redeveloped as part of the long-term-care redevelopment program. That deals with some of the issues related to small, inefficient long-term-care facilities that currently exist—the anticipation that redeveloping them will help to expand their size and increase the efficiency.

But you're absolutely right. This, as mentioned earlier in my remarks, is probably the primary challenge in large community as well as academic and small community hospitals: the challenge that you eloquently described as the increasing proportion of ALC patients. It simply reflects the demographics of Ontario. The current growth rate in Ontarians over the age of 75 is about 3%. We expect that to go up to about 5% per year in the next seven years. Certainly this requires a full answer across all of the resources available to care for frail and cognitively challenged Ontarians.

As you mentioned, that starts with community care in the home. That's where Ontarians want to be cared for. They prefer to stay in the home as much as possible. And, certainly, the expansion of home care, home and community service by a 5% budget increase per year has allowed us to substantially increase resources for home care to the point that about 640,000 Ontarians per year now are cared for in long-term care.

The other facilities in the community are also areas we're looking at: potential for supportive housing. It's certainly something that has not increased over the past few years, and an important element of what we're trying to accomplish is expansion of that supportive housing component to the system, with support to health care needs through home care.

The challenge that Ontario hospitals have experienced has waxed and waned over the last 10 years. When I was CEO of a hospital down the road, the proportion of beds occupied across the province by ALC patients was about 16%. That went down, with a number of initiatives, to 12%. It's now about 15%. As mentioned, we recognize that as the biggest challenge that hospital leaders have in terms of effective use of their facilities.

In terms of occupancy, that has resulted in some hospitals in over-occupancy and in the use of spaces that are not what we think of as most appropriate for patients in small numbers of cases. So the ministry has commitments to continue investments in-community, continue redevelopment of long-term care to make our long-term-care homes more effective—

Mr. Jeff Yurek: Chair, excuse me. I'm sorry to interrupt, but you've really gone off large hospitals on this, so I'm going to just jump in.

Dr. Bob Bell: Please.

Mr. Jeff Yurek: You said you had 10,000 beds added. I'm just wondering if you could give the committee the list of where these 10,000 beds were built—

Mr. Randy Hillier: These were new beds.

Mr. Jeff Yurek: New beds, you said. If we could have a list of those, because it's not jiving with the numbers we have.

Anyway, I'll just carry forward with the ALC portion. You made reference to your restorative and rehab care model, which is stating that you're getting rehab twice a day, seven days a week.

I'll give you a story of a constituent of mine named Mary, who had cardiac failure and renal failure and was put in a hospital to resect some of her bowel. Unfortunately, after the surgery, she needed rehab. I don't know if your program doesn't reach the South West LHIN or not, but she had rehab once a day, five days a week, and not on weekends, because they didn't have someone on the job to do rehab, which kept her back longer and longer—which might speak to the fact that we have so many people in ALC.

I don't know if the ministry is properly funding the hospitals in order to have an accurate amount of staff to provide these rehab services to get them out. How many years did you freeze funding—four or five years?

Dr. Bob Bell: Was that at Parkwood, possibly?

Mr. Jeff Yurek: No.

Dr. Bob Bell: It was at another purposed facility for rehab in the southwest. So this is—

Mr. Jeff Yurek: But how many years did you freeze the funding for? Was it four or five?

Dr. Bob Bell: For which hospital?

Mr. Jeff Yurek: For all hospitals, from the government freezing the budget.

Dr. Bob Bell: I can't really state that. I mean, various hospitals have had various increases. Last year, the overall increase in the hospital budget was 2.85%—

Mr. Jeff Yurek: That was the first one. I'll say five years, then. It would be five years of frozen funding. You would tend to see—

Dr. Bob Bell: Other hospitals, small hospitals, had a 1% increase each year.

Mr. Jeff Yurek: You would tend to see services being retracted, and I think it shows. This program was supposed to start in 2013 and now 2016. You'll note the number of ALC patients has increased. Has there been a review of this program and its effectiveness? Because, to me, I can't see any benefit, or an increase in reduction of ALC patients over the last five or six years.

Dr. Bob Bell: ALC did go down, up until—two years ago?

Ms. Melissa Farrell: Last year.

Dr. Bob Bell: Last year. It started to increase again last year. We absolutely recognize that, and currently are planning more types of investments in various places in the community sector that will help us to deal with the ALC issue.

Just going back to the issue of rehab, if I may, Mr. Yurek: One of the important things to recognize is that hospitals are able to redistribute resources. When I was CEO of the Toronto Rehabilitation Institute, for example, one of the things we did do was institute exactly what you're describing—rehab on weekends—by shifting around resources so that we could ensure that patients in rehab were indeed getting rehab on a seven-day-a-week basis.

Mr. Jeff Yurek: So who is to ensure that's happening?

Dr. Bob Bell: Care models within the hospital are dependent on the leadership of the clinical teams and the management teams, to organize resources in the way they think most appropriate to serve the needs of their patients.

Mr. Jeff Yurek: Do you set that as a target? You're promoting it as seven days a week, twice a day. To me, if the government's promoting that, that would be a target and a goal to reach. How do you monitor that it's happening?

Dr. Bob Bell: That's in the assess and restore program, I think, that you're referring to, which is targeted at frail seniors.

Mr. Musyj, you had a comment?

Mr. David Musyj: Yes, thank you.

Dr. Bob Bell: If you could introduce yourself, David.

Mr. David Musyj: David Musyj, president and CEO, Windsor Regional Hospital.

Just echoing the comments made by my colleague, I want to thank the Auditor General's team. Once again, we were subject to an audit—I think it was on infection control—back about eight to 10 years ago. We were part of that process.

Even though you're always hesitant when you get the phone call from the Auditor General, saying they're coming down to examine large community hospitals, we embraced it and appreciated your team spending time with our staff, because we take it as an opportunity to take stock of what we're doing and to learn from it and move forward. We really appreciate you and your team, and the work you did and the report you produced.

Just on your point: In Windsor Regional Hospital's experience, if you were to back up to just 18 months ago, two years ago—in our two acute-care sites, we have approximately 550 beds. Over 100 of them would be occupied by alternate-level-of-care patients waiting for either long-term care, rehab, complex or home care etc.

Just following on what Dr. Bell stated, we identified that clearly as one of the priorities, and a key priority, for Windsor Regional Hospital and our region, knowing the stresses on the system and knowing the stresses on bed capacity.

We took the opportunity with the LHIN, with the Windsor-Essex CCAC and with Windsor-Essex assisted living, and really focused on how we can use the resources that are available and the investments that are available from the ministry on home care to get that number down. I won't go into it, but I could pop up our

ALC number right now on my phone, at this second, as it stands, and I can tell you that that number hovers now around 30, when it was over 110.

1320

You might ask: How did you do that? How did you get there? It was through the investments of the Ministry of Health on community care access centres; it was the creative investments with assisted living. And yes, we talk about it: Patients and families do want to be at home. Sure, there is the exception, those who would rather, because of family situations or whatever, have their loved one in the hospital because home is too complicated. That happens; that's life. We all have family situations. But the statistics that Dr. Bell indicated are true to Windsor Regional Hospital. We have made significant gains.

It has resulted in us looking at the resources we have and providing that rehabilitation service over the seven-day period. It also has required us to make significant investments in what we call utilization managers, which are front-line registered nurses and social workers who help the families and support the families at home. Having CCAC in the building, in the hospital—so the day a patient is admitted, you're talking about discharge, and you're looking at lengths of stay. We've been able to accomplish a lot of that through those investments.

Could it ebb and flow, and go back up? For sure. No doubt about it. But we've made significant investments. And especially at a time where there are bed capacity pressures that we're facing, if we were at 110, we would have been toast with respect to ALCs. The staff did a great job getting it down to where it's at. The services are being provided at home. The patients are not returning to the emergency department; they are being taken care of at home, and it's been successful.

All I can say is, if you had talked to me three years ago, I would have been one of the ones saying that it's a major crisis. I know it's a big issue across the system, but over the last 18 to 24 months, there has been significant focus in our region on getting that number down, and I credit the community that we talked about with a lot of the success.

Mr. Jeff Yurek: How many minutes left?

The Vice-Chair (Ms. Lisa MacLeod): Lots of time: seven minutes.

Mr. Jeff Yurek: The report also stated deferring surgeries—mainly due to funding not meeting the demand. I can tell you that in the South West LHIN, many of the hip and knee surgeries are done their funding by October. They talk about having to defer types of surgeries into the following year. Maybe the people from the hospitals can give me a number? Do you track how many procedures you defer year to year?

Ms. Michelle DiEmanuele: We don't defer surgeries. That's language I wouldn't be used to hearing. You said that in October, you're done. That wouldn't be the case for us. We look at the funding that's allotted to us. In some cases we are given numbers around the numbers of procedures we can do in any particular area, and working with our specialists—our physicians and the surgical department—they will look at the priority list, the wait-list etc. and make a determination based on clinical evidence as to what should go forward or not. That is spread out through the course of a year.

The Vice-Chair (Ms. Lisa MacLeod): Mr. Hillier.

Mr. Randy Hillier: Just to follow up on that, and maybe if there are others here—in the report, it shows that 58% of hospitals responded that they do defer surgeries. You're saying that in your hospital, you don't defer any surgeries?

Ms. Michelle DiEmanuele: Defining "defer" for me—if you could just define that. Do you mean in terms of when we're on the day of a case, where we may bump the case or something?

Mr. Randy Hillier: No, no. This is talking about deferring from one fiscal year—

Ms. Michelle DiEmanuele: Oh, to another?

Mr. Randy Hillier: —into the next fiscal year because of lack of or the exhaustion of the budget.

Ms. Michelle DiEmanuele: On very rare occasions would that occur in our—

Mr. Randy Hillier: So you're one of the 40%.

Ms. Andrée Robichaud: I'm Andrée Robichaud. I'm from Rouge, representing Rouge here. I think we were the first one to go through the audit, so thank you very much. It was actually a good experience. We learned a lot, and we've improved a lot since your report.

We do not defer from year to year. I have my chief of staff here, and we do not.

Dr. Bob Bell: Maybe I could just comment on that, because there is no question that we could improve the timeliness of surgery by looking at the distribution of care across—

Mr. Randy Hillier: What we're trying to get at is, how many people? If 58% of the hospitals are responding that they are deferring surgeries into the next fiscal year, what does that equate to in how many patients? How many patients are not getting the required surgery and having it deferred into the next fiscal year?

Dr. Bob Bell: We could tell you that, for example, there are about 117,000 cataract patients who get surgery every year. I don't think we could tell you the number that could be deferred in the fashion that you're describing, Mr. Hillier. What we can tell you is that patients are treated according to the urgency of their need. For example, patients who have cataract surgery: The vast majority of them are still driving. They have better than 20/50 vision.

Mr. Randy Hillier: So the ministry doesn't track and the hospitals don't track how many people are deferred who were scheduled to be in and have their surgery done before March 31 in a given year and who are then told, "No, we don't have it. You have to wait."

Dr. Bob Bell: The way we track it is not on an annual basis. We track it by wait times advised to us by expert panels: What's the appropriate time for someone who has a cataract, for example, with better than 20/50 vision or worse than 20/50 vision? What's the right time for them

to get access to care? I can tell you that 86% of cataract surgeries are performed within target, 77% of hip replacements—

Mr. Randy Hillier: We see all the numbers, but we have this statement from hospitals saying that people who are scheduled then get deferred. I've seen it first-hand with my constituents, people who were scheduled for a knee, a hip or a cataract surgery, who were then told, "We have used up our quota of knees, hips or cataracts and you'll have to wait to next year."

Ms. Michelle DiEmanuele: Mr. Hillier, can I answer that? I understand what you're getting at.

First off, there are a number of reasons why something may, and I'll use your language, be deferred into another fiscal year. For example, recently in our hospital, there was a burst pipe in our surgical area, which had us actually shut down for a number of days. This happened in the last quarter of this year. So we had to cancel many surgeries, and those get rescheduled—

Mr. Randy Hillier: No, I'm not talking about the one-off, the exceptional—

Ms. Michelle DiEmanuele: But I'm just trying to suggest to you that there are a number of reasons why. That would be a reason. There could be a patient reason, who may cancel; they were not well enough. Then there may be, on certain procedures when you get to the end of the year, where a hospital may, for whatever reason, make a decision to, I'll use your language, defer. That has not typically happened at Trillium in terms of our procedures, but we are capped in certain areas. To your point, we are capped—

Mr. Randy Hillier: Okay, but we have—

Ms. Michelle DiEmanuele: If I could just finish, please. We are capped, and if you are not managing—and I think the deputy talked about managing—during the course of the year, you could find yourself in a situation where you've reached your cap and you still have a way to go. Those are the kinds of things that we actually do track.

Mr. Randy Hillier: So those people are deferred? That's a long way of saying that they're deferred.

Ms. Michelle DiEmanuele: If you were a hospital that was not looking at, on a daily, monthly, quarterly basis, how you were mixing your resource base with the patient population coming through the door, you may not get the right balance on that.

Mr. Randy Hillier: Well, let me just refer to a couple of other statements. There's another statement in here that, "Long surgical wait times put patients at risk." Here's another one: "Patients waiting too long for some urgent elective surgeries." "Wait time for elective surgeries varies across Ontario," and information is "misleading."

Maybe, Mr. Bell, if you could: Are those statements correct? Or do you not believe that those statements are correct?

Dr. Bob Bell: With absolute respect to the Auditor General and the report, there is some issue in the report related to urgent surgeries, especially in neurosurgery, where the P2 neurosurgery times are not being achieved according to target.

What's not recognized in the report is the remarkable improvement in providing emergent neurosurgical care that has occurred in the province.

Typically for acute neurosurgery problems—people with brain tumours, brain bleeds etc.—

The Vice-Chair (Ms. Lisa MacLeod): If you could just hold that thought—

Dr. Bob Bell: Okay, will do.

The Vice-Chair (Ms. Lisa MacLeod): —and I'll turn it over to the third party. Madame Gélinas.

1330

M^me^ France Gélinas: Well—

Dr. Bob Bell: Would you like me to continue?

M^me^ France Gélinas: I'm going to point you in a slightly different direction, but you're going good. In the auditor's report—I'm on page 454, if you are ever interested in following up, but basically talking about wait times. The example that she gives is hysterectomies. We see that we have a level of urgency of high, medium and low. We have a target wait time for 90% of the cases. In high, it's 28 days; medium, 84; low is 182. Then we have the actual, which is at 65, 132, 156, if you're interested.

Then we have what is reported to the public. What's reported to the public is that you took a weighted average of the high, medium and low and said that the weighted average is 148 for the actual wait time for 90% of cases. But then when it came to targeted wait times for 90% of the cases, you only show the low, which is at 182. For the life of me, why did we do that?

Dr. Bob Bell: This goes back to consultations with the Ontario Hospital Association and Health Quality Ontario, especially with patients. It's the old adage in quality improvement: If you provide too much data, you're providing no data, right? So what we did was, we tried to take a huge number of wait-lists for—how many procedures?

Ms. Melissa Farrell: Two hundred.

Dr. Bob Bell: Two hundred procedures, and make it into something that was relevant. We agree with you: This is not the most accurate way of reporting. We have taken a new look at this with patients, and we will be presenting a new way of describing wait times on a consolidated website sometime in the next four to five months, I believe?

Ms. Melissa Farrell: Yes.

Dr. Bob Bell: Yes, sometime in the not-too-distant future, reflecting some of the concerns raised by the Auditor General and some of the concerns that you're raising today. I'll stop there.

M^me^ France Gélinas: So we all agree that to have a weighted average when it comes to the actual—so you have the weighted average of high at 65 days, medium at 132, low at 156—makes your average go down, but when you look at the target wait time, you only looked at the worst of it, so you were set up to show something that was way better than it ever was in reality. How did anybody come to agree to put that kind of data forward?

Dr. Bob Bell: The wait times that we published are wait times that are clearly described. Could they be more accurate than what you're describing for various levels of patient need? Yes. The kinds of data that we publish is signed off on a regular basis by external experts, including the president of the Ontario Hospital Association, the president of Accreditation Canada, people like that. We're planning on changing this and evolving this. This is the way the wait times are published across the country. This provides us with comparability with other jurisdictions.

The other thing that's important here is that keeping the same methodology for reporting wait times allows us to look at improvements over time, with the investments that have been made in wait-time procedures.

M^me^ France Gélinas: So you're telling me that if I go to all of the other provincial jurisdictions, they all take the low-level urgency target wait time and they report on the high, medium and low average together?

Ms. Melissa Farrell: Melissa Farrell, the ADM of health system quality and funding with the Ministry of Health.

It's a similar methodology that's used in other provinces to report the wait-times information. There are really two reasons why the Data Certification Council, who actually signs off on the data reporting for this and has membership from ICES, from HQO and from—it's an independent group that signs off the data reporting, when we initially started this. Data is also tracked by Cancer Care Ontario. It's not tracked by the ministry.

There were two main reasons why this information was actually captured within the total, and that's low volume. The challenge with some of those priority levels, the lower-priority levels, is that there is lower volume for it. As a result of that, we would be showcasing a lot of no-to-low volume that would have been published, and that would be difficult to translate to patients when talking about it.

Secondly, there is volatility in those waits. Because it's low volume, there is variation month to month, so you would not see consistent waits, which is also more difficult to present.

Having said all that, we are, as a result of the audit, looking at the way in which this is publicly reported, and changing the way in which we're publicly reporting it, to make sure we're reporting this information more accurately for patients.

M^me^ France Gélinas: You realize how damaging it is to the trust in our health care system when people realize that you have taken the highest target, at 182, and that you have given them a composite that is sort of meaningless once you put high, medium and low together? How could it be that all of those experts in our health care system lost track of common sense? If you're going to use a target that has to do with low acuity, then you give them the time for low acuity, and you don't go and get other stats in there that make your stat look good. You realize how much damage you have done to the trust of Ontarians in our health care system when you publish things like that?

Dr. Bob Bell: If we look at various institutions—the Fraser Institute, CIHI—who have responded and reviewed the wait-times reporting by various provinces, and constantly commend Ontario as having, really, best performance in reporting wait times—totally agree with you that we need to look at this constantly and improve it.

The other thing that I'll mention, Madame Gélinas, as someone who has used wait-time data to actually influence who you're going to operate on in the next week—the other thing to remember here is that this data is not only used for public reporting. It's also used for structuring OR time. It's used for determining who is next on the OR list. There are many reasons for recording data in this way, in addition to simply public reporting.

Certainly, maintaining the higher-priority cases, and the time they've been waiting, is crucial for surgeons to plan appropriate care for patients.

M^me^ France Gélinas: I agree with everything you've said. What I disagree with is that when I go onto the Ontario Ministry of Health website, and I look at what the target is, I am being given the target for the low acuity, without knowing that this is a target. You just say that this is the target. When I look at the actual, I'm being fed a mix of actual and I cannot figure out which one was high priority and which one was medium. You mix them all together.

Dr. Bob Bell: There are so many different mixes here. Going back to the issue of neurosurgery, where this is also an issue, the Auditor General points out that P2—priority 2—cases in neurosurgery only meet wait times in the large community hospitals' wait-time targets.

Actually, in the most recent data from the two hospitals that undertake neurosurgery, Trillium Health Partners and Windsor, they're meeting their P2 wait-time targets about 50% of the time. That doesn't sound terribly good, except when you consider that P2 cases only comprise, across the province, about 400 cases per year, whereas emergency neurosurgery patients, who have the same conditions as P2 patients but are more acute, are being looked after within 24 hours. That sums up to 9,000 cases.

When you look at the various distributions across the various care categories, there is actually sophistication in the breakdown that's needed in each and every one of these surgical sub-areas. You really have to know what's going on at each level of care, including emergency access to care, to understand how well patients are being looked after.

M^me^ France Gélinas: I like what you're saying, Deputy, but let me be clear: If this is what is meaningful, then tell us, "Here is the high-acuity neurosurgery. Here is our target, 24 hours, and here is how much we do." Don't give us an amalgamation of data that makes Ontario look good, because you know—and you've spoken about this eloquently many times—the importance of the trust in our health care system. When we see things like this, you do a whole lot of damage to our health care system by publishing data that, on one side, deals with

the low acuity, and on the other side, mixes all three. If in neurosurgery, it makes sense to talk about the high-volume procedures that are high acuity, sure, report on that. It seems like this is common sense.

What you have there is damaging.

1340

Dr. Bob Bell: We appreciate that, and we are modifying this, as you've described.

The only other thing I'd mention is, we are reporting data on 200 interventions. When you start looking at four different classifications within those 200, you start getting into 800 different indicators. You wonder if it's actually meaningful to report on 800 indicators to the public.

M^me^ France Gélinas: I agree, but giving misleading information is not helpful to anybody.

Dr. Bob Bell: We do describe what we're reporting on. We're not trying to mislead.

M^me^ France Gélinas: I'm going to stay with wait times again. This one has to do—

Dr. Bob Bell: If I may, I'll just mention, other provinces only report low-acuity cases. That's all they report. So 182 days is the typical wait time reported across the country.

M^me^ France Gélinas: So they don't do like we did and mix it all together? Please follow the lead of the other provinces. That would help.

Dr. Bob Bell: No, they do. They would say a patient with uterine cancer—all patients need to be treated within 182 days.

M^me^ France Gélinas: Okay. If I can keep on—

Mr. David Musyj: Can I just comment? Do you mind?

M^me^ France Gélinas: Go ahead.

Mr. David Musyj: Again, it's David Musyj, president and CEO of Windsor Regional Hospital.

Just on this whole point about wait times: The one thing we find at Windsor Regional Hospital is getting to the issue of—there's just a lot of data to be collected, produced and reported on. Even going through the audit with the Auditor General, the information that's publicized is only as good as the information they get from the hospitals.

So I'll take partial blame, if not a lot of the blame, with respect to the data that the ministry reports on, because—for instance, with the neurosurgical cases that Dr. Bell was talking about, that only 50% are done within the time. As we dig deeper into the work we do and as a result of the audit, we find out that there are some decisions that we're making on a hospital level with respect to those particular patients and those cases. The physicians and the clinical team are making decisions on, when is the appropriate time to do that surgery? But we start the clock ticking with respect to the wait time, which artificially inflates the wait time for that particular patient, and we're reported. It's not accurate. It artificially inflates it. I'm not saying that in all the cases, but it doesn't take a lot of that data to be thrown in to start artificially creating problems with the data.

So it's not only as the ministry looking at, with patients, on how to better report this, but as a hospital—I can speak for Windsor Regional Hospital—we're looking at it as a better way for us to collect this data and make sure it is accurate.

Sometimes, we have actually gone into the physicians' offices, because we have to look at wait times for knee surgeries, wait times for hip surgeries. Some of that data in their office is—there's a particular patient who will come forward and say, "I'm going to get my hip surgery done." That patient then makes a decision: "Don't have my hip surgery done before April 1, because I'm going to be in Florida all winter." Unfortunately, what happens is, physicians' offices get busy, it gets complicated, they forget to extract that patient and stop the clock—because that's a patient's choice. As a result, those days get added to the wait time and artificially inflate the wait time.

So it's working with all of the players and trying to give the ministry the most accurate data as possible. But I can tell you, at a hospital level, part of the problem is, we have to do a better job collecting it, because that's what's being reported.

Again, I'm not saying that's across the board, but it does happen. With the Auditor General coming in, they identified some of these issues with their preliminary data and said, "Look at this." They give you a preliminary review of data at your hospital level, and we say, "Oh, jeez." Then we start digging into it, and we say, "Yes, that's right. That's what's being reported, but it's not accurate."

So part of this process is learning how to clean that data up and make sure it's as accurate as possible, because, like you said, people in the public—clearly, that's who it's meant for—rely upon it. We have to make sure it's as accurate as possible. Part of the blame is on the hospital level.

M^me^ France Gélinas: That's very generous of you.

The next part—

Mr. David Musyj: It's the truth.

M^me^ France Gélinas: Yes. The next part also has to do with wait times. I'll read from the report:

"As part of the Wait Time Strategy announced in 2004, the ministry established guidelines for how quickly emergency surgeries should be performed." But there are no "formal targets for hospitals to report against....

"None of the hospitals we visited consistently track sufficient information to assess the timeliness of surgeries and document reasons for surgical delays....

"At the three hospitals we visited, we found that 47% of patients had to wait on average over 10 hours more than the ministry's two-to-eight-hour guideline....

"However, our own assessment of emergency-surgery wait times found that, overall, 38% of patients in our samples who required emergency surgeries did not get them within the time frames recommended by the ministry." And it goes on.

On this one, my question is simple—it's hopefully a yes or a no—are we looking at tracking those types of surgical wait times, reporting on them and making those public?

Dr. Bob Bell: You'll notice the term "guideline" being used here. Within our guidelines, there are discrepancies. You can look at guidelines for emergent access. We call something a compound fracture and we call it an open fracture in level two.

We purposefully do not recommend time for various conditions because it's such a critical issue that the physicians, nurses and administrators running Ontario's operating rooms are able to make appropriate decisions based on assessment that would be inappropriate for the ministry to impose.

As a former manager of the largest operating rooms in Canada—the Toronto General and Toronto Western, medical director of those operating rooms—these are decisions that need to be made by regulated health professionals in the minute. How long can a patient wait? Some open fractures, I can say as an orthopaedic surgeon, could wait for six to seven hours without concern. Others need to be operated on immediately. It's inappropriate for the ministry to actually set anything more than simple guidelines as a bit of policy advice to our operating room colleagues.

Michelle?

M^me^ France Gélinas: Sure.

Ms. Michelle DiEmanuele: I just want to echo what the deputy said, but to your principal point around the tracking, certainly, the conversations we had with the auditor gave us a lot of insight into where we can do more internally in our own structures. While I agree completely with the deputy that we want the trained surgical teams making those decisions—and it's not just assessment, but it's constant reassessment during those periods of time—equally so, we need to stand back and look at that information, because that helps us make better decisions about where we may need to expand our surgical platform to be able to accommodate more effectively and where to put our resources over the course of the year, over the course of weekends, off hours and 9 to 5 during the day. It's important, and I think that is one area where we're certain we're going in a stronger direction.

M^me^ France Gélinas: Okay. I'm going to have to change focus because I've been told that I have four minutes left.

The Vice-Chair (Ms. Lisa MacLeod): You're getting the guillotine in three minutes.

M^me^ France Gélinas: Down to three? Okay.

The auditor also makes a recommendation that rather than giving physicians privileges into our hospitals, some hospitals should consider actually employing physicians. Have any of you given that any thought? And, Deputy, I know that you're in negotiations; please don't share with us anything we're not supposed to know.

Mr. David Musyj: That would be dramatic.

M^me^ France Gélinas: But that being said, it seems like an idea whose time has come; anybody else agree with that?

Dr. Bob Bell: I'll just start off by saying that there are physicians who have roles that we call hospitalists across hospitals in the province, who play a crucial role in providing excellent care to Ontarians who have contractual relationships with hospitals.

With that, I'll turn it over to my colleagues.

Ms. Andrée Robichaud: I can speak to having had the experience of a salaried physician coming from another jurisdiction—I'm from New Brunswick—but they are also privileged. Although they're paid in a certain way, they also require privileges.

M^me^ France Gélinas: Oh yes, I didn't phrase that properly. How did it work in New Brunswick?

Ms. Andrée Robichaud: Well, I would say that in certain disciplines, it worked quite well.

M^me^ France Gélinas: Name me some.

Ms. Andrée Robichaud: I think hospitalist is one of them; for pediatricians, it was quite effective. There were some areas where it worked quite well.

The Vice-Chair (Ms. Lisa MacLeod): And maybe I'll just stop you there.

M^me^ France Gélinas: Really? I still have a minute seven on my clock.

The Vice-Chair (Ms. Lisa MacLeod): Okay.

M^me^ France Gélinas: I'll use it for Mr. Musyj.

Mr. David Musyj: I agree strongly with that. I think that as we move towards—we have a lot of physician groups who are on alternative payment plans or alternative funding plans where their OHIP will go to the hospital and the hospital in effect pays them "a salary or a stipend" for the performance of the work. We find that very beneficial.

Just on your point, I think that if you google the president and CEO of the Cleveland Clinic—he did a video years ago. They asked him why his organization is such a high-performing organization nationally and internationally. He indicated that the first thing is the fact that, as physicians—

The Vice-Chair (Ms. Lisa MacLeod): I really will have to stop you there this time.

1350

We are going to 17-minute rotations now. We will now go to the governing party.

Mr. John Fraser: If you want to finish what you were saying.

Mr. David Musyj: Just that the president and CEO of the Cleveland Clinic—they asked him why his organization is such a high-performing national and international organization. Right at the start of his video, he indicates that the number one reason is the fact that his physicians are employed by the Cleveland Clinic, and he uses the words, "Everyone's rowing in the same direction when you have that." I've gone down to the Mayo Clinic, and the same type of scenario is there. They are very high-performing organizations, and very positive.

If Dr. Bell can pull that off, I'd like to see it, and I will cheer him on in the background.

It does work. We're as close as we can be in certain areas, with respect to the alternative payment plans that are worked out, that were indicated with respect to pediatricians' hospitals. It's the equivalent of it, and we

see in those areas that it works very positively for the system.

Mr. John Fraser: Where doesn't it work?

Mr. David Musyj: Where we don't have it currently is in the surgical areas. I think that's what the Auditor General was getting at, because a lot of the focus of the report is with respect to the operating room and surgical times.

Rowing in the same direction with respect to even physician compensation at certain times of the day—elective schedules versus emergency cases—if we could go down that road into the surgery area, I think we would see some success as a system.

Dr. Bob Bell: The only other thing I would mention, Mr. Fraser, is that you'll remember the scope of the meeting last week, where we talked about the fact that Ontario has, by far, the highest proportion of primary care physicians in the country who are on a contractual basis with respect to their rostered populations.

Mr. John Fraser: So there's the rub in wait times, right? What are the challenges? How do you pull everybody together, working—I won't go into it too much.

I think that in Ottawa, we began with a single queue for orthopaedic surgeries. I remember how difficult it was for that to be pulled together, because it required everybody rowing in the same direction and spreading the work out. We had orthopaedics who were fully booked for 18 months, and some who were just trying to find some time in the room. I know that we've made some progress across Ontario on that, and I think that's a great thing.

For my colleague across the way, it's recommendations 6 and 7 that I'm speaking to right now.

I want to go back to the wait times and the characterization that somehow wait times—the way that we record them and put them out there—are misleading. I think that's an unfair comment from my colleague across the way, and I will explain why. I have a question about that as well.

When wait times first came out, for the average person looking at that, it was hard enough for them to understand, with medians and 90th percentiles. It's not just a tool, obviously, for the consumer. It's complex. You've got complexity of cases, right? You've got different teams of physicians. You've got different facilities. That was a way of measuring things that worked for all people who were in the system. It seems to be something that was agreed upon across all the provinces.

Having said that, it is a public-facing website and reporting mechanism that lets people know where they can go, or where the services are most readily available, or what they can expect. I know that the auditor made some recommendations in regard to that reporting.

Can you just comment on that? What are we doing to address those recommendations?

Dr. Bob Bell: Why don't I start off?

Ms. Melissa Farrell: Sure.

Dr. Bob Bell: Thanks for that question because, again, I'll repeat the fact that I wasn't there at the start of wait times, as Melissa was. This was a huge step forward, as you described, Mr. Fraser, in terms of both public accountability and, crucially, managing wait-lists for a surgeon, actually characterizing their intensity of need.

There are two problems that we're trying to address currently. The first problem is the fact that our wait times are rather scattered. You find them on cancer care websites. You find them on various websites. We're going to consolidate them all into one place, so that you can find emergency department wait times, wait times for primary care, wait times for surgical procedures and wait times for long-term care in the same place.

Again, this is a huge amount of data, so we've done a lot of work with patient groups—Patients Canada and other patient family advisory committees—asking them, "How do you want us to express these times?" Is the same time for long-term care the time that we should be expressing for emergency departments? Obviously not. We need to have times that are contextually appropriate to the service that we're describing.

Melissa and her team have done a huge amount of work in the past year, both on website development and on thinking through with citizens how they want to see these times expressed.

Melissa, do you want to describe some more?

Ms. Melissa Farrell: Yes, I think there are a couple of other points that I would just raise. One of them, just to reflect on a point that you just made, is that it can be really confusing for patients.

We've also seen in the media, when reporting on wait times, the 90th percentile versus the median or average wait. In fact, often they assume that what we're talking about is the average versus it truly being the 90th percentile, and the public thinks that it's the average as well. So certainly when we're thinking about what the public presentation should be of the wait times, we think building in the average is going to be really important to how that gets publicly reported on a go-forward basis.

The other thing that Ontario has, though—there are only a few other provinces that do—is access to specialist wait times, which is that wait 1 that the deputy was speaking about earlier. Wait 2 is what's publicly communicated today, and that's the wait from the time that the decision to treat has been made to the actual treatment. What is missing in terms of understanding the true overall wait time is the wait from primary care to see the specialist in the first place. That really makes up the total comprehensive wait for a patient; that information is currently being collected, and we're trying to find the best possible way to determine how to share that information too.

Dr. Bob Bell: You might say, "Well, what's the problem with just sharing that information for wait 1 and wait 2?" Of course, the problem is that if we use the 90th-percentile time to see a specialist, then the 90th-percentile time to have surgery, the natural inclination is just to add those two together. Of course, that does not represent the experience of any patient. Those are the worst times of one and the worst times of the other.

You might say, "Well, why don't you actually track individual patients?" Of course, what we're talking about is getting clinicians to provide information, so now we need to get the primary care provider to give us the time that they sent a patient off to see the orthopaedic surgeon, and then the orthopaedic surgeon to record the time it takes that patient to get into the operating room. You can imagine, without having their unique identifiers—because that would be personal health information we wouldn't want to be gathering for administrative purposes—the inability to link together wait 1 and wait 2 means we've really got to think carefully about how we express this data.

Mr. John Fraser: Thank you for speaking about the 90th percentile, because it really did cause—not everybody got through second-year stats, right?

Ms. Michelle DiEmanuele: Or first.

Mr. John Fraser: Or first, yes. So it's really hard for the average person to understand, and it's critical that it's something that's meaningful there. I hope that that's what you're going to get to.

I'm glad you brought up the issue of primary care to specialists, because it is something that I hear about—I don't want to say frequently, but I hear about it from time to time. The deputy is well aware of how I feel about transitions and how we have a system that is complex and made up of individuals, and we don't always take people from one place to the next.

Instead of taking them there—I'm not going to go to my "take them to the peas" analogy, because this place has heard it often enough, but we don't say to people, "I'm going to take you and bring you there and confirm that you're there, and confirm that it's acknowledged that you're there." I think measuring that time will be critical in actually trying to create an ethos or a standard that says—I know that many people do this, but when you see it fall down, it's because somebody sent the referral over and it got over there on the fax, but on this end they never checked that it was there; at this end, somehow it didn't work out. I've heard more often than not when that happens, the patient says, "Well, I didn't get a call for six months." There's still a lot of natural deference in our health care system. That's changing, and that's a good thing.

1400

Anyway, if you could speak to that piece, because I think that's a really critical piece to try and change that. We have a lot of great care, but when that transition doesn't work, that's where things fall down.

Dr. Bob Bell: Thanks for that question. The way you've eloquently described it, it is just begging for an IT solution, right?

You'll be happy to know that in the Waterloo Wellington local health integration network, that made-in-Ontario out of the primary care electronic medical record to the surgical specialists, the medical specialists, with a warm electronic handshake—and with times being recorded, is currently in place and has been shown to dramatically improve the patient experience.

Our anticipation and hope—Minister Hoskins, I know, wants to extend that across the province. That's something that we really hope—along with the great program that developed in the Champlain LHIN for e-consultation, which stops the patient from having to travel, that's also spreading across the province. So, a couple of solutions to the concern that you're expressing.

Mr. David Musyj: Just on that point, before we lose it, your point is well taken. We have a process. We brought the two acute-care campuses in Windsor together under one umbrella about three years ago. We're working through this process called standardization and optimization, where we're looking—because they were under two organizations previously—working as teams under both facilities and standardizing our processes and optimizing our processes to increase patient satisfaction and, at the same time, go to the highest common denominator rather than the lowest, and involving patients in those discussions.

One of them is your example with respect to the paper flow of work. In the past, a referral would come in for an MRI. Sometimes that referral gets lost. And you said, us as Ontario individuals—Canadians are very complacent sometimes, and we'll just sit back and wait for the call to book the appointment, and the call never comes. Then, six months later they call the hospital and we find out that we misplaced the referral and they have to start the process again.

One of the simple things we did—you'd think it's very simple, but you've got a lot of moving parts—is that the moment we get the referral now, within 24 hours we call the patient to say, "We received the referral from your referring physician, and here's the date of your appointment." They might not like the date of their appointment, but at least they got it and at least they have it. Then we work on, "Okay, you're on a cancellation list and we'll move you up. Or, if things change and the urgency changes, we can change the date." But that simple thing has made a world of difference. So within 24 hours, if you don't get that call, that means it's lost and the patient isn't sitting back asking, "Did they forget about me?"

That point you raised is so important on system changes that we as hospitals need to make. And the way you make them is—it's amazing. You bring the patients into the room, and they'll tell you what system changes you need to make. Just like they're saying with respect to wait times, you get the patients in the room and they're going to tell you what it's like with respect to the 90th percentile and what that means. To my mom, she wouldn't figure—no disrespect; she's smarter than I am, but she wouldn't figure out the 90th percentile because I can barely figure out the 90th percentile.

Ms. Melissa Farrell: There was just one other point I wanted to raise based on the points that you just raised about primary care to specialist access. Some of it is an electronic support, but it's also what Fredrika had started to talk about and was in fact part of the key recommendations in the audit report: We should really be scaling and spreading these models of central intake and assessment.

You were talking about the Champlain model in particular. It has changed the wait times in terms of their performance when it comes to hip and knee in Champlain. They used to be the worst performer and are now one of the best performers on hip and knee as a result of putting in central intake and assessment. Largely, that's because we have people who are sitting on wait-lists waiting to see a specialist when, in fact, they could actually see someone else through that process, to determine whether or not they actually require the surgical intervention or some other support for that patient too.

We take that recommendation quite seriously. We think that what's really important for us to be thinking about is, we have some pockets of excellence when it comes to central intake and assessment, and where can we spread and scale that provincially, to support more than just hip and knee—in fact, MSK—and you can see it with other specialist services too.

I don't know if the hospitals want to comment further.

Mr. David Musyj: There was a recent article in the Windsor Star that talked about wait times based upon this ICES report, which reported some of the wait-time information.

Part of it had to do with the knee surgery wait time in Windsor, timed from primary care to specialist, and specialist to surgery. Sure enough, that exact point is happening in Windsor. There is one particular surgeon who is under great demand, is very well liked and has a reputation of performing expert knee surgeries. Unfortunately, his wait time is driving up the rest.

It's difficult. You work your best with your team in addressing these issues, trying to get the overall wait times down, and have that discussion, but it's not as simple, with respect to getting that to happen.

But if it's going to be tied in the future to being able to reduce wait times, that you must move towards a system that the deputy minister and assistant deputy minister have identified as being successful, that will force the issue at a hospital level and will result in better patient care. We will see exactly what happened in Champlain—we'll see it in Windsor.

The Vice-Chair (Ms. Lisa MacLeod): Thank you very much. We'll now move to the Progressive Conservative caucus and Mr. Hillier.

Mr. Randy Hillier: Thank you once again. Just for clarification, in the first round, Dr. Bell, you mentioned that there were 10,000 new beds, and there was a request that you provide the committee with where those new long-term-care beds have been allocated.

For clarification, that was new bed licences. What period of time were you referring to, when you said that there were 10,000 new long-term-care beds?

Dr. Bob Bell: Thanks for that, Mr. Hillier. I've confirmed that since October 2013, approximately 10,000 new long-term-care beds have been developed, and approximately 13,500 older long-term-care beds have been redeveloped.

Mr. Randy Hillier: Okay. Thank you very much.

Going back, we heard from—I don't know if I can pronounce your name—David Musyj.

Mr. David Musyj: Close enough.

Mr. Randy Hillier: Close enough?

Mr. David Musyj: You pronounce it the way it's spelled.

Mr. Randy Hillier: You mentioned that wait-time data is not accurate. I think that's a quote—

Mr. David Musyj: No, no, no. Now you're overgeneralizing what I said, Mr. Hillier.

Mr. Randy Hillier: Well, that's what I wrote down as you were speaking. Maybe there was—

Mr. David Musyj: Well, unfortunately, if that's what you heard, it's incorrect. Sorry.

Mr. Randy Hillier: You did reference that the data was inaccurate on the wait times, and you gave a number of examples as to why it would be inaccurate.

Mr. David Musyj: Yes. Clearly, unfortunately, you didn't hear what I said—with respect. What I was getting at is there seemed to be a big push around the table with respect to the wait time that's being produced by the Ministry of Health as being misleading to the public. I'm not saying it is, because at certain points—let me put it this way: I agree that too much data just becomes very confusing for the general public. That's what is being examined now; let's take a step back. But by producing it, not only has it been helpful for the public, clearly, but also internally. We, as hospitals, use that—I'm telling you—on a daily basis. We look at that.

Mr. Randy Hillier: Yes, I heard that part.

Mr. David Musyj: What I identified is that if there is a problem with some of the data, it's our responsibility as hospitals to do a better job in collecting that data, because the ministry is just taking our information and producing it. What I indicated is that the auditor—

Mr. Randy Hillier: But you gave an example of somebody who decided to be in Florida, but they're still being included on the wait time.

Mr. David Musyj: Right, so—

Mr. Randy Hillier: That's when you used that example to say that there are inaccuracies in the wait-time data.

1410

Mr. David Musyj: When the Auditor General came in and identified some of the wait times and really focused in on, "Here are some wait times for particular procedures," what we did, and what I think all the hospitals did, was we took that information back—because that was the purpose. The Auditor General gave us that data to say—I don't know what you called it, but there was an accuracy tester to make sure it was accurate and find out if there were any flaws. We went in and started digging, and as we started digging in deeper with that data, we found out, on a hospital level, that we can do a better job as a hospital in making sure—

Mr. Randy Hillier: So the data is not perfect.

Mr. David Musyj: It's not perfect, and I don't think anyone in this room is making a claim that it's perfect. But it's a heck of a lot better—I'll use the proper phrase

because I know it's being recorded—a heck of a lot better than nothing.

Mr. Randy Hillier: So it's not 100% accurate, then.

Mr. David Musyj: Yes, but it's not—between 100% accurate to misleading is totally different—

Mr. Randy Hillier: That's right. But we also heard from the member from the third party about this weighting of wait times as well and how that confuses or muddles and brings in some concern about the integrity of the health care system and the data that we're seeing.

Again, back to Dr. Bell: Last week when you were here, you identified that the data for physician billing was uncertain, was unreliable, and questioned the accuracy of the data for physician billing. I'm beginning to wonder, are there any elements of the Ministry of Health where the data is, with certainty, an accurate depiction of what it is that they're trying to showcase? Or are these targets and things just better named as "stretch goals"?

Dr. Bob Bell: David, do you mind if I jump in?

Mr. David Musyj: No. Go ahead. I tried.

Dr. Bob Bell: Terrific. Listen, Mr. Hillier, what you're describing is data being absolutely 100% accurate, reflecting the experience of that patient. It's pretty good. I can tell you, as somebody who has recorded data and has used it to make clinical decisions of who's next on my operating list, the data is doggone good and reflects clinical reality. Does it reflect it within one or two days instead of three or four days? Relatively speaking, it's excellent data.

Going back to the issue of does the Ministry of Health know what's going on: With respect to wait-time data, I can tell you that we know that there were exactly—I'm going to make up the number, but it's close to the real number—117,000 cataract operations done in this province last year, and we can tell you every person who got one. We can also tell you—

Mr. Randy Hillier: But you can't tell me who wanted one but couldn't get one—

Dr. Bob Bell: Well, we could tell you—

Mr. Randy Hillier: Who needed one—

Dr. Bob Bell: No, that's not true.

The Chair (Mr. Ernie Hardeman): Let him answer the question.

Dr. Bob Bell: People who saw an ophthalmologist and were told that they may want a cataract operation, but their lack of visual acuity or the development of their cataract is not yet sufficient for them to qualify for surgery—that happens every day. That's a clinical, professional decision. We do not know that; you're absolutely right. We only know the people who are considered appropriate to be on a wait-list, based on professional assessment of their current clinical condition. They go on a wait-list based on the clinician's interpretation. We know all those people. We know what happens to them.

Mr. Randy Hillier: Yes, we know that they're on a wait-list, without a doubt.

Dr. Bob Bell: And we know when they get their surgery.

Mr. Randy Hillier: That's right.

Dr. Bob Bell: And then they did get their surgery.

Mr. Randy Hillier: I'm going through this. We know that there are a number of surgeries that get deferred. We know also through this that there is a waiting period to get into surgeries. The statement was that people are waiting too long for some elective surgeries. We also know that the infrastructure in many of our hospitals is underutilized. We know that there's a demand for certain procedures, certain surgeries. We know that there is a lengthy delay, stretch goal or whatever it may be, but we also know that most operating rooms are not utilized in the evenings, that they're not utilized on the weekends, that they're not utilized on statutory holidays, that they're closed for March breaks and weekends and weeknights. We know that there is a demand for health care services—I guess instead of using the word "demand," I will say there is a medical necessity for these procedures. We have long wait times or deferred procedures, and then we have all this infrastructure, bought and paid for, that sits idle and empty.

What is the ministry doing to clean this mess up? Because we have a demand, a medically urgent demand for these things, and they're sitting empty.

Dr. Bob Bell: Thanks for that, because I think it's a misconception that hospitals close their operating rooms at 3:30—

Mr. Randy Hillier: Most of them.

Dr. Bob Bell: I'm sure that every hospital represented by my three colleagues has very important cases that are being done, possibly through the night. I know in the hospital I used to lead, the operating room was working 24 hours a day, 365 days a year.

Mr. Randy Hillier: So this statement from the Auditor General is incorrect, that most sites visited had nine to 12 operating rooms, and only one at each site remained open all the time?

Dr. Bob Bell: Oh, no, that's correct. It may not be the full nine to 12—I'll ask my colleagues.

Mr. Randy Hillier: So they're underutilized. They're sitting empty, many of these operating rooms.

Ms. Michelle DiEmanuele: Bob, do you want me to speak to this?

Dr. Bob Bell: Please, please. Michelle.

Ms. Michelle DiEmanuele: We provide services seven days a week, 24 hours a day. You're correct that in the evenings, you wouldn't be running a full set of OR rooms, and on the weekends, you'd be running your emergent OR rooms etc.

There are a couple of things, though, when you think about the utilization, that it's not just about OR time. It relates to your relationship with your physician. So we had a conversation for a few minutes around the relationship with physicians. You'd have to be able to work out your arrangements with your individual practitioners around their coverage times. We have collective agreements that would have to be considered.

I can tell you that in our hospital, a couple of things are happening. Number one, we have been looking at and moving to a six-day-a-week schedule, because we have

one of the largest demands in the province. If you've looked at our data, we were doing tremendously well on wait times for several years, and we're starting to see them creep up again. We believe we are going to have to look at both extended hours—and we're in active conversations with our surgical department and with our bargaining agent partners about how we would do that; obviously it's not just about our professional services, but all of the workers in our hospital who would have to make that happen, and all of the related services: lab services, pharmacy services. It's not just about—

Mr. Randy Hillier: But you already have all those relationships already established, from 8 till 5.

Ms. Michelle DiEmanuele: If you go into—I'll pick a gas station. If you go into a gas station right now, there are a number of people who are working, and then after hours, you know less people come in.

We know when our loads are: Between 8 in the morning and 8 at night is when we feel the largest load across all of the organization, and so we staff accordingly. I'm just suggesting, sir, that it isn't just a question of open up an OR; you have to make sure all of the services are there to support that procedure being done.

Mr. Randy Hillier: Well, sure. But if the gas station had a lineup of cars a mile down the road, all wanting to get fuel, they would bring in some extra people.

Ms. Michelle DiEmanuele: Correct, and that's the conversation you would need to have around your relationship with physicians. It isn't just as simple for me to say I'm bringing in more staff. I have contractual arrangements I have to pay attention to. I have arrangements with my physicians on which hours they are prepared and able to perform surgeries, in this case, around your question, or whether they're going to be on call, or the emergency department or any of the other services we provide.

Your principal point, though, around the opportunity for us to be able to look at how we're using the resources that government provides us to be able to provide—and I believe this is the conversation we had with the auditor—additional services is an important conversation for us to have. I know in our hospital, we are actually looking at how we could move, not just our surgical services, but other services that the public needs. I think of a simple thing: "I just want my health care record." Most people can't go between 9 and 5 to get their health care record. We now open up in the evenings for those patients who need to come in and get health care records. I think there is a great conversation to have in that regard.

1420

Mr. Randy Hillier: Okay, so it's not a case of funding or anything; it's just a case of establishing contractual relationships—

Ms. Michelle DiEmanuele: And funding is a part of that. Funding is absolutely a part of that.

Mr. Randy Hillier: Okay—

Dr. Bob Bell: Mr. Hillier, just one other thing, if I could, briefly: just the issue of appropriateness, because it is not as if people are waiting desperately for surgery. I realize there are some cases—

Mr. Randy Hillier: I've had a number of constituents for whom it would be a very big difference.

Dr. Bob Bell: Let me speak on average. On average—I've mentioned cataracts—we do about 117,000 cataract surgeries a year. It means there are about 45,000 people on the waiting list. Those people are functioning. They're driving their cars. If they're not driving their cars, they're going to have much more rapid access to care.

When we look, at the ministry, at appropriate distribution of resources, we have to make tough decisions about long-term-care funding, home care funding, emergency department funding, versus paying CEO DiEmanuele's overtime costs for keeping an operating room open longer to reduce the number of cataract surgeries.

We have excellent data that helps to make decisions as to the distribution of resources with partners, like the CEOs.

Mr. Randy Hillier: You talked about cataracts. I have specific examples I know of, where people were on the wait-list and were being delayed to such an extent that they did go through private services to get those cataract procedures done, because they did not want to jeopardize—the loss of their driver's licence and further ramifications and consequences for them. They had to go elsewhere.

But I do also want to just briefly—one of the things that I see on these wait times in Ontario—and I would like to get a comment on this. Alberta, British Columbia and Saskatchewan publicly report wait times by individual surgeons, where Ontario does not, and I think that's a huge negative for the people looking for services.

I can say, I've gone driving down to Florida this year. You see on the interstate these big signs: "Wait time at the emergency room: five minutes or five hours" or whatever. Knowledge helps people make good decisions. They need to have the information. It needs to be accurate information, but they need to have it be available.

In Ontario, are you looking at providing that individual wait time for surgeons? I know that it took me two years to get to see a dermatologist. That's how long the wait was for me.

Dr. Bob Bell: For dermatology, one of the real opportunities is the use of e-consultation with pictures—anyway, I won't bother with that.

But the issue with respect to choosing your wait time: The central intake and assessment program that started in Mr. Fraser's LHIN is going to come across Ontario in this next year and a half. People will be offered the choice. The next available surgeon with the shortest wait time—45 days—is Dr. Smith. You wanted to see Dr. Bell. He's got a wait time of 220 days. You can choose, but we will make available the shortest wait time for the next patient.

The Chair (Mr. Ernie Hardeman): That concludes the time.

Mr. Randy Hillier: Okay. Thank you.

The Chair (Mr. Ernie Hardeman): We now go to the third party.

M^me^ France Gélinas: Very good. I'm going to shift focus for a while. One of the stats that came out of the report that really surprised me—and I still, in my mind, cannot explain how Ontario ended up there.

It starts with: "Of the 57 large community hospitals, 60% of all medicine wards had an occupancy rate ... of 85% or more.... There is much research to show that occupancy rates higher than 85% not only result in longer wait times for hospital beds ... but also increase the risk of transmitting infectious disease."

It goes on to say that the data from CIHI shows that, in Ontario, of all of the provinces, we have the highest rate of sepsis following surgery.

How come Ontario is at the bottom of the pack? Can anybody explain that to me?

Dr. Bob Bell: Maybe I can start. About two years ago, we started extending a program called NSQIP to all Ontario hospitals. That's a program that is now, I think, across probably all three of the hospitals that are here. It gathers a huge amount of surgical information on patients and allows us to compare relative performance at various hospitals.

One of the questions related to recording patient data in NSQIP relates to recording any sign of infection around the surgical wound or any evidence of a urinary tract infection, all of which are coded by CIHI as septic outcomes.

There is a term, "sepsis," that refers to people in dire straits with septic shock—a terrible outcome. That's not what CIHI is reflecting here. This is one of the outcome measures that has the worst recording across the country, and I think part of the reason why we're seeing Ontario having a higher "sepsis" rate is simply that we do a far better job of recording the data.

We're delving into that now with the NSQIP data. It allows us to compare our surgical results to the only other province in Canada that has done this—that's BC—and more importantly, to large academic and community hospitals in the US. I can tell you, our data looks very, very comparable, if not better than most.

M^me^ France Gélinas: So CIHI ranked us 10 out of 10 provinces because we do a better job of finding who has an infection than all the other provinces, is your answer?

Dr. Bob Bell: That's certainly one of the reasons, yes.

M^me^ France Gélinas: What are the other ones?

Dr. Bob Bell: Well, that's the reason that I could refer to here. The way that CIHI reflects surgical sepsis—they recognize it as being a problem. Let me give you an example. Our hospitals trace patients from discharge to 30 days post-op. If a patient gets an infection in Ontario hospitals 30 days post-op, that's recorded. Most provinces don't have anything like that. The post-op follow-up offered by our hospitals, I will say, is definitely better than other provinces across the country.

M^me^ France Gélinas: Okay. Do any of the hospital CEOs want to add to this, or are you happy with the answer?

Ms. Michelle DiEmanuele: I would just say we're seeing that go down in our hospital. It's an important indicator and one that we've focused on, and we've seen a decrease in the last few years in our rate.

M^me^ France Gélinas: What did you do to get it to go down?

Ms. Michelle DiEmanuele: It's focus, and it's the clinical team looking at individual cases and reflecting on that and learning from those particular issues. I know, just in terms of practice, I can think about our orthopaedics group and one of the physicians telling me—we were a merging hospital and they were doing something in one site differently than in another site, and that led to a decrease because they changed how they were treating the patient post-op etc. Those are just some of the examples.

M^me^ France Gélinas: Okay. Mr. Musyj, I'm going to go back to you. In your answers to the report, you said that you have bought and are in the process of installing a new nursing scheduling IT program. Can you tell us why you're doing this?

Mr. David Musyj: That's a scheduling system to schedule staff—so actually in our whole LHIN, Erie St. Clair LHIN, the hospitals purchased the scheduling software. We just rolled it out. One of the smaller sites rolled it out first so we could learn from them how the rollout happened, so when it comes over to a larger site—the basic reason is to keep track and schedule staff. Our management team does it manually right now and spends a considerable amount of time, and if you can get an electronic system—my colleague to my right indicated there are a lot of collective agreement issues. You need a master's degree, pretty much, to schedule staff these days because of the various collective agreement provisions. If we can lean on an electronic solution whereby we can put in all these rules with respect to the collective agreement and then put the staff in with their requests with respect to which days they want off or to work, it makes it a lot easier for everybody and reduces the errors.

M^me^ France Gélinas: All right. I also noticed that you are the only one of the three that does not employ agency nurses. Is this a decision you've made, that you were not going to do this, or is it just because you never needed them?

Mr. David Musyj: In our jurisdiction, we don't need them.

M^me^ France Gélinas: You don't need them?

Mr. David Musyj: Yes.

M^me^ France Gélinas: Okay. Sorry, you wanted to—

Ms. Michelle DiEmanuele: I was just going to say, with the scheduling piece, there are two other components to that, because we are also looking at doing that. One is that it creates fairness. I think, David, you were getting at that: the underlying fairness around how employees are treated. It also helps you manage not just overtime but sick time and issues associated with that.

1430

M^me^ France Gélinas: What are your policies toward agency nursing?

Ms. Michelle DiEmanuele: We use agency nurses in our hospital.

M^me^ France Gélinas: Yes, I saw. Of the three, you were the highest user.

Ms. Michelle DiEmanuele: Less than 1% of our total amount of nursing wages—I'll talk about nursing specifically—I think it is about 0.67% right now that goes to either overtime or agency, so a very small percentage of our total operation.

M^me^ France Gélinas: What is the decision-making process that leads to that phone call to the agency?

Ms. Michelle DiEmanuele: There's quite a triaging of that. On any given day, a couple of things might lead you to think about using additional staff. Firstly, it could be sick calls. A number of people could call in, and that would require you to staff up in a different way. Typically, the manager on the unit will look at if there is availability of their current complement of staff. Secondly, we have a very robust float pool, not just in the nursing area, but in other areas of the hospital, where we can call staff in from our float pool who get deployed on any given day to the various areas. That also offers quite a variety and diversity of work for the staff, so it also has the benefit of that. Thirdly, again, depending on the situation, you may look at bringing in a casual from another area of the hospital, not within your own area. Then, you might—

M^me^ France Gélinas: I know how schedules work. I worked in a hospital for a long time—

Ms. Michelle DiEmanuele: Well, you asked me what the decision-making piece was—so we work our way up; an agency would be what we would resort to at the end. It is not a preferred option. It would be what we would do towards the end.

M^me^ France Gélinas: Okay.

Ms. Andrée Robichaud: If I can add to that, I think we're at the same stages in introducing the schedule system. But one of the nice components—and we're going live in September—is that the system can actually send an email for casuals and part-times. We've been decreasing our agency time, and that will help us in decreasing agency time.

M^me^ France Gélinas: Okay. My next question has to do with log-out on active computer systems. You all read the report; I don't have to repeat it. In your mind, is there a target time that you think should be implemented where we would have automatic log-out? Because I saw the response that you gave, and it seems to me that the length of time before automatic log-out is still quite large. How did you come to this? I will start, again, with you, Mr. Musyj, because you addressed it directly in your response and gave specific hours for different scenarios.

Mr. David Musyj: Yes, thank you. Again, you think things are simple and, unfortunately, one thing I've learned in health care is that I never come across anything that is simple anymore—in the world, for that matter, or life in general.

There was a lot of discussion again—it was on a LHIN level where we had this discussion as well. There's the balance between, clearly, privacy and confidentiality and the clinicians wanting to be logged in 24/7, 365 days a year and never log out. You have to have that discussion and those balances. It started at, I think, 12 hours, now it is down to four. There is a continued push to try to get it down, so we're going to go down to four and see the clinical outcomes of that with respect to the feedback from our clinicians with respect to, does that create problems for them, having it log out in four hours? So it's doing that balancing act.

M^me^ France Gélinas: Have any of you looked at this new technology where it's your ID badge that turns your computer on and the ID badge that shuts it off, so that it comes on and off? How expensive are those things anyway?

Mr. David Musyj: You start looking at HIS systems—and I think everyone will comment on this. HIS systems are very expensive when you get into that type of technology. We are actively, as a hospital, looking at investments. I know the ministry has done a considerable amount of work with respect to clusters, trying to have hospitals work together with natural clusters and natural patient flows on trying to get economies of scale with respect to HIS systems. That would be part of those benefits of a high-end HIS system.

M^me^ France Gélinas: Okay. Deputy, this is a short one for you: The ministry website often makes reference to 152 hospitals. The Auditor General uses 147, and gives us the list of 147. When you started your speech, you started at 143. How many hospitals do we have?

Dr. Bob Bell: I think I'd better get back to you on that, Ms. Gélinas.

M^me^ France Gélinas: Wrong answer, Deputy. Wrong answer.

Dr. Bob Bell: We had 54 large community hospitals as of the time this list was made up, 57 small community hospitals and 15 teaching hospitals. But the number of hospital corporations—for example, Hotel Dieu in Kingston just announced its merger with Kingston General Hospital, so there is a degree of variability and flex, given the day of the year that we measure the number of hospital corporations in the province. So I'd say today: 143?

Ms. Melissa Farrell: The only point I wanted to just raise is that at times we include private hospitals when we're talking about the total overall number. That's the reason why you'll also see some difference in the number: whether or not we're including public and private, or just including private or, I guess, just talking about public.

M^me^ France Gélinas: You started your speech today saying, "There are 143"—and you did say "public hospitals," so I take it it's public. Do we have five or six private? We had an argument this morning.

Ms. Melissa Farrell: Six.

M^me^ France Gélinas: Six?

Ms. Melissa Farrell: Yes.

M^me^ France Gélinas: I win.

Dr. Bob Bell: There you go.

Mr. David Musyj: What do you win?

M^me^ France Gélinas: Nothing—the argument.

Interjection.

M^me^ France Gélinas: Exactly. Okay. That was very quick.

Deputy, back to you: We have our advanced practice physiotherapists, who see most of the hips and knees and then have the conversations with the patients who do not require surgery, so that the orthopaedic surgeons don't have to have that discussion anymore—because once they are referred to them from the advanced practice physiotherapist, there's a good chance that they'll need surgery. It doesn't exist in all the LHINs yet. Does it exist in all of your three LHINs?

Mr. David Musyj: For Windsor Regional, the answer is no. We actually just had this discussion very recently, that we've seen some positive results as a result of that, and we look forward to working on implementing that. Because I think it was—I forget where it was trialed at.

Dr. Bob Bell: Champlain has had extremely good results, and we're moving it toward London right now, so it will be in the South West LHIN very soon.

Ms. Michelle DiEmanuele: We have it in our spine program.

Dr. Bob Bell: And you, of course, have the ISAEC program, so this is spreading rapidly.

Mr. David Musyj: Yes, and with some very positive results.

M^me^ France Gélinas: That kind of leads me to the next question. If we take hips and knees, is there an intention to roll it out throughout all of the LHINs, as well as with spines, where we move toward a centralized assessment? Is this being rolled out? Is this something that the ministry is actively doing?

Dr. Bob Bell: There are three programs in musculoskeletal that have really demonstrated tremendous patient impact. One of them is the central intake and assessment that Champlain has demonstrated great results with. One of them is the so-called ISAEC model, which you know about, for back pain. Another one is the Rouge Valley shoulder program. All of these deal with problems where the surgeon shouldn't be the first person who sees the patient, nor should imaging be the first thing that's undertaken for the patient.

We're looking at rolling these out, and there's probably going to be some local flexibility. Champlain, for example, is going to use their central intake model to implement their spine model as well. There will probably be some local differences in the way that it gets rolled out.

M^me^ France Gélinas: Do you have a time frame before those are rolled out to all 14 LHINs?

Dr. Bob Bell: I can't give you a really exact answer on that, but I'd say that in the next year to a year and a half we should see central intake and assessment in each LHIN, and ISAEC probably in the next two years in most LHINs.

M^me^ France Gélinas: Okay. So this is something that the ministry is committed to.

Dr. Bob Bell: Yes.

M^me^ France Gélinas: Okay, very good.

Interjection.

M^me^ France Gélinas: I still have two minutes? Okay.

The Chair (Mr. Ernie Hardeman): You've got three.

M^me^ France Gélinas: Three? All right.

I want to come back to the last question I asked regarding the use of physicians—salaried physicians or alternate payment plans for physicians. Just to give me an idea, in your hospitals, have you got any alternate payment plans? How is it working? And would you like this to expand, and to where?

Ms. Michelle DiEmanuele: I'd have to go through the list, but we certainly have a variety of ways we pay our physicians: We have hospitalists, like we talked about previously; we stipend in certain areas to create a relationship; we have AFPs; and we are right now in conversations even around practice plans in our hospital. So we have a real variety. It depends on which program and which group of physicians you're talking about.

1440

M^me^ France Gélinas: Okay. Would you like to see more of this moving forward or—

Ms. Michelle DiEmanuele: I think anything that allows—I mean, our physician population is absolutely invaluable to delivering effective health care in this province. Anything that provides an opportunity for the hospital operations and the physician expertise to come together in a way that optimizes, we should be exploring. I think there are a number of ways that can be done.

M^me^ France Gélinas: And I see you shaking your head.

Ms. Andrée Robichaud: I would agree with that.

M^me^ France Gélinas: Can you describe how it is in your hospital?

Ms. Andrée Robichaud: I would say we're comparable. We have, in our ER at the new organization that I'm interim at—there are different pockets and different models. AFP is very conducive to some types of practices and not to others, so I think a mix of that lets us provide good care and appropriate care.

M^me^ France Gélinas: Are most of those negotiated through the OMA agreement?

Ms. Andrée Robichaud: Yes.

M^me^ France Gélinas: They are. Okay.

Dr. Bob Bell: There are some, for example, hospitalists, doctors working in hospitals, that are, generally speaking—some individual fees are negotiated through the schedule of benefits and the physician services agreement, but there are also individual contracts with the hospitals.

M^me^ France Gélinas: Do any of you have a physician on straight salary, very similar to community health centres, where they work on salary for a number of hours?

Ms. Michele DiEmanuele: Our chief of staff, for example, would be on straight salary. He is also on service for us in the hospital.

M^me^ France Gélinas: And the other two hospitals? Do you have any physicians who are on salary?

Mr. David Musyj: No, but the equivalent is you get an alternative payment plan that's very similar. And the way you structure that with respect to a mixture of fee-for-service and the alternative payment plan—you can structure it in such a way that—

Interjection.

Mr. David Musyj: Yes, cancer program—that you can create some incentives for the actual practitioner as well.

Ms. Andrée Robichaud: I would say, though, that the closest physician to a salaried physician is our pathologist. I know in our case, that's probably the closest thing.

Ms. Michelle DiEmanuele: That would be pretty common across most of our hospitals, outside our three.

M^me^ France Gélinas: So when the auditor makes recommendations to move physicians toward salaries so that they are part of the team and row the boat in the same direction, do you see this as something that the ministry should continue to push?

Mr. David Musyj: From my own personal view, yes, we should continue to look at that and move that along, because it has worked positively in other jurisdictions around the world.

Again, I think one of the areas that we spent a lot of time focusing on and that the Auditor General focused on was the surgical area. That's one area where it is absent, so we have to look at that.

M^me^ France Gélinas: None of you have it for surgical specialties?

Ms. Michelle DiEmanuele: I'll just take a quick look—not that I'm aware of.

M^me^ France Gélinas: Deputy, does it exist anywhere in Ontario?

Dr. Bob Bell: Yes, there are occasional surgeons who are on more of a salaried model. I'd say that even in a salaried model, the way that the contract works is that any surgeon in virtually any jurisdiction in the world has expectations as to the number of surgeries performed as being a service level that is part of the contract. It's crucial for transactional services that the number of services are counted and the compensation somehow relates to that.

The Chair (Mr. Ernie Hardeman): That gives you the full three minutes. Thank you very much.

That concludes the time. We thank you for being here today to help us.

Dr. Bob Bell: Thank you very much, Chair, and thanks to the Auditor General. We appreciate it.

Ms. Bonnie Lysyk: And thank you for the co-operation.

Mr. Randy Hillier: Chair, I'd like to move a motion, a notice of motion.

The Chair (Mr. Ernie Hardeman): A notice of motion?

Mr. Randy Hillier: Yes.

The Chair (Mr. Ernie Hardeman): The Clerk is distributing the motion—

Interjections.

The Chair (Mr. Ernie Hardeman): Order. Order. The member has moved notice of motion for a motion. There is no debate. I just want to report that that motion will be on the agenda next week. I think the Clerk has distributed a motion.

With that, that does conclude the public portion. Now we can have a few moments' recess while everybody can enjoy their departure.

The committee recessed at 1445 and later continued in closed session.

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